National Alliance on Mental Illness

Testimony before the Appropriations Committee
February 20, 2009
Department of Mental Health and Addiction Services Budget

Good evening, chairs and members of the Appropriations Committee. My name is Sheila Amdur, and I am here to testify today on behalf of the National Alliance on Mental Illness, CT (NAMI-CT).

The Governor proposes closing Cedarcrest Hospital and replacing the beds with 64 beds at CT Valley Hospital (CVH), thirty "community placement" beds, and ten beds at Greater Bridgeport Mental Health Center. The thirty beds would be transferred to the community in two large 15-bed facilities. Instead of investing in these "mini-institutions," the state can use these dollars for small supported housing, group homes, or other homelike settings that promote community integration. An estimated 30% of the consumers at Cedarcrest Hospital do not need inpatient level of care, but there are no other appropriate options. In addition, the state could work with non-profit hospitals to provide some of the intermediate inpatient care now provided at Cedarcrest, and the state could receive Medicaid reimbursement which it now cannot be paid for state hospital inpatient care. State workers would be crucial in proving the community support services for people to be integrated back to the community.

It is our understanding that about $6.2 million is being proposed for renovations at CT Valley Hospital (CVH). Instead of investing in "bricks and mortar" at CVH, these capital dollars can be used for supportive housing. We do not want to continue a pattern of continuing institutionalization, but use this as an opportunity to break the logjam in inpatient care and support people who need to return to the community with the appropriate services and housing.

In addition, if you add up cuts in Crisis, Community Support and Case Management, there is about $8.26 million to be taken out of community mental health services over the next two years. When we can't get people out of hospitals and ER's, why would the state continue to starve the community system, even if we are developing "new" models? Reducing dollars for any community mental health services is still taking funding out a system that is beyond paralysis.

It is critical that the state move forward with the 150 units of Supportive Housing that the Governor committed to two years ago - these are shovel ready projects that will provide desperately needed housing for veterans, families with children, and people with disabilities who are homeless. The Governor has backed away from this commitment by halting the funding. Without sources of capital financing for the creation of affordable and supportive housing, there will be no new affordable or supportive housing created. Connecticut desperately needs these units, without them the state will lose money by having to pay for costly institutionalizations and emergency care. Supportive housing is permanent, independent and affordable housing combined with on-site or visiting case management, support and employment services. Persons with psychiatric disabilities have few options for finding safe, affordable, and permanent housing

within the community. With a place to live and the right treatment and medications, many people with serious mental illnesses are able to engage in recovery and lead happy and fulfilling lives.

NAMI-CT strongly supports the Governor's proposed funding for caseload growth in DMHAS Young Adult Services and for the state's new Waiver for Persons with Mental Illness.

Despite efforts by DCF and DMHAS to meet the dramatic increase in demand for services for youth and young adults, the status of young adults with psychiatric disabilities in Connecticut is reaching crisis proportions. According to DMHAS, the referral trends threaten to thoroughly overwhelm the entire system of care, elevating what has already been observed to represent heightened risks for critical incidents affecting both our clients and the community (DMHAS, April 2007).

The Governor is proposing a little over $4 million over the next two years to fund additional placements under the Medicaid Waiver for Persons with Mental Illness. The state can maximize federal revenue by increasing the number of persons with mental illness to be served under its Medicaid waiver and take advantage of the increased federal match under the stimulus package. Currently, the waiver allows Connecticut to serve 72 persons in each year of the waiver, for a total of 216 persons. However, in 2006, DMHAS estimated that 420 individuals with mental illness in nursing homes had "high discharge potential." The state has lost an estimated $7.5 million in Medicaid reimbursement because the number of persons with mental illness in some nursing homes has exceeded the federal limit. During the past two years, DMHAS and DSS have developed their infrastructure to pursue nursing home discharges, and this should support an expanded waiver population.

We are also attaching to our testimony a proposal that highlights how the state can increase Medicaid revenue and improve community services. Times of crisis should be times to find ways to do things better, and not just times to further oppress those who are the most vulnerable.

SAVING MONEY, SAVING LIVES

Since the Governor's Blue Ribbon Commission (BRC) Report was issued in July, 2000, Connecticut has pursued initiatives to replace an institutionally-biased, crisis-oriented and fragmented approach to mental health care with a more cost-effective, community-based, person and family focused system. While some progress has been made, the state's current fiscal dilemma challenges us to review recommendations and consider measures that could be implemented both immediately and longer term to improve the state's efficiency and outcomes while preserving vital housing and services. The goals are to:

- Maximize federal revenue while strengthening the community system of housing and supports,
- Reduce reliance on expensive long-term, institutional settings, including out of state placements, and
- Promote community integration in accordance with state policy and federal law.

Maximize Federal Medicaid Revenue

Both DCF and DMHAS have already collaborated with DSS to increase federal reimbursements under Medicaid by expanding the services covered under the state plan for the low income individuals they serve. This is particularly significant given the expected increase in the federal Medicaid reimbursement rate under the stimulus package. However, there may be more services for children that could be covered under HUSKY or the Behavioral Health Partnership, and there are many DMHAS services currently state grant funded that could be covered as optional[1] rehabilitation services under Medicaid[2].

Expanding Medicaid Adult Rehabilitation Services

An actuarial study conducted by the Mercer Consulting Group for the Department of Social Services (DSS) identified in their February 2004 published study the following ***new federal revenue for these existing DMHAS services as Medicaid rehabilitation services:***

Assertive Community Treatment Teams (ACT)	$10,554,692
Supervised Housing (services only)	11,141,684
Supported Housing (services only)	7,074,768
Mobile Crisis	6,167,272
Total estimated	$34,938,416[3]
Targeted Case Mgt. current revenues	7,000,000
NET NEW FEDERAL FUNDS	**$27,938,416[4]**

Due to concerns about expanding an entitlement and disrupting the community providers, OPM and DMHAS have moved cautiously on Medicaid coverage for adult mental health services, only covering rehabilitation services at group homes thus far. However, since that study was issued, the state has allocated funds to build the capacity of community providers to comply with Medicaid requirements.

In addition, the state has received federal approval to operate a home and community based services waiver for persons with mental illness who can be diverted or discharged from nursing homes which will start April 1st. In the course of developing this waiver, DSS and DMHAS have developed service definitions and a rate-setting methodology for services to be covered under the waiver. Two of these, assertive community treatment and

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[1] The state can also expand Medicaid under the 1915(i) state plan option, which enables states to provide a prescribed set of home and community based services to individuals that earn less than 150% of the Federal Poverty Level and require less than institutional levels of care.

[2] The federal Medicaid program has both mandatory and optional services.

[3] Group homes are excluded since DMHAS and DCF are already proceeding with coverage of their services under the Rehab Option.

[4] Mercer Government Consulting Group, ***Estimate of the Budget Neutrality of the Connecticut Behavioral Health Partnership, Technical Appendix,*** Feb. 2004, Appendix J.5.

community support services (included as ACT in the Mercer study), could be covered by the Medicaid state plan expanding the population served and increasing federal revenue, possibly during SFY 2010. The capacity building required to bill for services in supervised and supported housing requires further investigation.

In order for the Medicaid maximization of community mental health services to work long-term, DMHAS must retain grant funds for the transition costs into Medicaid fee-for service, non-medical services (social support), and non-Medicaid eligible clients. In addition, the rate-setting structure must cover the cost of providing services, and funds must be targeted to expand housing options and services for individuals with complex needs. The impact of these measures must be monitored to report the outcomes on inappropriate institutional and emergency room care.

Expanding Medicaid Waiver Slots

The state can also maximize federal revenue by increasing the number of persons with mental illness to be served under its Medicaid waiver. Currently the waiver allows Connecticut to serve 72 persons in each year of the waiver, for a total of 216 persons. However, in 2006, DMHAS estimated that 420 individuals with mental illness in nursing homes had "high discharge potential." In addition, the State has lost an estimated $7.5 million in Medicaid reimbursement because the number of persons with mental illness in some nursing homes has exceeded the federal limit. During the past two years DMHAS and DSS have developed their infrastructure to pursue nursing home discharges, and this should support an expanded waiver population.

Maximizing Medicaid Billings for Outpatient Services

Federal revenue can also be maximized by assuring that outpatient services provided by state operated and contracted providers are billed to Medicaid to the fullest extent allowed. Services provided by state operated programs and facilities are billed through the Department of Administrative Services not DMHAS. DMHAS and other state agencies do no direct billing, nor are their budgets dependent upon any income generated. The state should determine if standards regarding productivity, timely and accurate billing, and targets related to income recovery have been established to maximize what the state does collect for its billable services.

Increasing Medicaid Funded Intermediate Care at Private Hospitals

DMHAS presently operates 830 inpatient psychiatric beds, with no federal reimbursements for any patients between the ages of 21 to 65, with the exception of a small number of persons with Medicare coverage. This means that the state pays 100% of the cost of care. The per capita cost of the 572 licensed beds at CVH, originally built in 1867, is $1177 (based on SFY 06-07), an increase of roughly 37% in five years, and the per capita cost of the 128 licensed beds at Cedarcrest Hospital, built in 1910, is $1284, an increase of more than 39% in five years.

Except for services provided in the Whiting Forensic Division, and some specialized inpatient long-term treatment, the intermediate inpatient mental health treatment and the alcohol and drug inpatient treatment provided at state facilities could be provided at many general hospitals if they were adequately compensated for the cost of providing that care and a system for assuring discharges to stable and appropriate settings, not shelters, were in place. This would require that DSS establish a new Medicaid intermediate inpatient service rate with specific provider standards for treatment, rehabilitation, and discharges that would be closely monitored for compliance and outcomes.

Investing in Cost-Effective Housing and Community Services

Transferring some intermediate inpatient care services to private hospitals could both alleviate the gridlock in the state's mental health system and create an opportunity to consider transferring resources from inpatient settings to the community. It is well documented that the lack of adequate funds for housing and community

services and supports for persons with psychiatric disabilities contributes to the utilization of nursing homes, prisons, shelters, emergency rooms and hospitals at a significant cost to the taxpayer and the individuals. Conversely, community options, particularly supportive housing, reduce hospitalizations, increase employment and education, and contribute to increasing neighborhood property values. Any state workers displaced could be transferred to provide the community treatment and support as was done when state hospitals were closed. The state's long term gain is in reducing institutional costs, gaining Medicaid payment for inpatient care, expanding resources for community integration without jeopardizing jobs, and concomitantly, reducing emergency room costs.

Reducing Institutional Costs for Children

Riverview state psychiatric hospital is the only state operated psychiatric hospital for children in New England. Its average daily census is under 70 patients, many of whom are referrals from the Juvenile Court for evaluations. At the same time, Connecticut continues to send children out-of-state, presumably because there are no state alternatives. The cost-effectiveness and efficacy of this facility and those out of state placements must be closely examined. Any actions regarding the intermediate inpatient psychiatric care for children and youth must be tied to strict treatment standards and a discharge planning process, to developing cost and care effective solutions, and allowing creative solutions with the state workforce at Riverview to address community alternatives or specialized in-state residential care for children placed out-of-state.

Expanding Alternatives to Incarceration

Currently, almost 20% of persons incarcerated in CT prisons and jails have been diagnosed with a mental illness. Since 2000, the number of inmates with moderate to serious mental illnesses rose from 2,200 to over 3,700 today. Along with homelessness and nursing home admissions, this is a stark example of the deterioration of our basic mental health system. Department of Corrections officials confirm that an estimated 1,428 persons with moderate to serious mental illnesses are incarcerated for low-level, non-violent offenses.[5] This represents a substantial number of non-violent offenders with mental illnesses who could safely live in the community, if they had housing and services. Instead of providing services and housing, the state spends approximately $40,000 to $60,000 per person to incarcerate people. Although it may not be possible to do a "one on one" closure of prison beds for every person we can take out of prison or divert from prison, over time we will reduce the number of prison beds. State staff who are no longer deployed to state institutions could form the core of new community supervised placements for diverting and discharging people from prisons who do not need to be there.

Planning and Oversight

As noted throughout this document, many of these measures require planning and oversight. The state has an existing strategic planning body that could oversee this process and present a report to the Governor and the Legislature by June 1, 2009—the Community Mental Health Strategy Board. Chaired by the Commissioner of DMHAS, the DCF Commissioner and a representative of OPM also sit as voting members of the Board, and other relevant state agencies have non-voting seats. Hospitals and advocacy groups also are members. There are currently vacancies on the Board to which union, consumer and family, and community provider representatives could be appointed.

[5] As of October 2007, the Department of Corrections (DOC) reported that of the 3,897 inmates with mental health issues classified as level 3, 4 and 5, 1,741 were not convicted of, or on bond for, a violent or serious offense (46%). The DOC reports the Mental Health level 3 numbers to be inflated by approximately 20% because they include inmates with problems that are probably not directly attributable to serious psychiatric illness. This still leaves 1,428 inmates with moderate to serious mental illnesses who are in prison for low level offenses.